House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

Signature of Sponsor

AMEND Senate Bill No. 185* House Bill No. 142

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 71-5-1002, is amended by deleting subdivision (h)(1) in its entirety and substituting instead the following:

(1) To make expenditures for nursing facility services under the TennCare program for FY 2017-2018 at the full rates for the specified fiscal year as set in accordance with § 71-5-105(a)(3)(B)-(D), that would have been subject to reduction by the bureau of TennCare for FY 2017-2018, except for the availability of one-time funding for that year only. Payment of full rates to restore a rate reduction from the bureau of TennCare as described in this section shall be satisfied only by the money available in the fund described in this section and before making any other payments from the fund;

SECTION 2. Tennessee Code Annotated, Section 71-5-1003, is amended by deleting the date "July 1, 2016" wherever it appears in subsection (c) and substituting instead the date "July 1, 2017"; and is further amended by deleting the date "June 30, 2017" wherever it appears in subsection (c) and substituting instead the date "June 30, 2018"; and is further amended by deleting in subdivision (c)(4) the language "FY 2016-2017" and substituting instead the language "FY 2017-2018".

SECTION 3. Tennessee Code Annotated, Section 71-5-1004, is amended by deleting wherever it appears, the language "FY 2016-2017" and substituting instead the language "FY 2017-2018"; and is further amended in subdivision (b)(1) by deleting the language "on July 1, 2016." and substituting instead "on July 1, 2017.".

SECTION 4. Tennessee Code Annotated, Section 71-5-1005, is amended by adding at the end of subsection (b) the following language:

However, § 71-5-1413 shall constitute the exclusive authority for rulemaking by the bureau of TennCare regarding the transition to an acuity-based nursing home reimbursement system when acuity and quality supplemental transition payments as authorized in § 71-5-1004 are transitioned into the medicaid per diem rates of that nursing home reimbursement system.

SECTION 5. Tennessee Code Annotated, Section 71-5-1006, is amended by deleting in subsection (c)(1) the date "July 1, 2016" and substituting instead "July 1, 2017".

SECTION 6. Tennessee Code Annotated, Section 71-5-1413, is amended by deleting subsection (e) and substituting instead the following:

(e) When acuity and quality supplemental transition payments that are made pursuant to § 71-5-1004 are transitioned into the medicaid per diem rates of the nursing home reimbursement system, the bureau of TennCare is authorized to adopt rules and regulations necessary to implement a new nursing home reimbursement system, subject to the following limitations:

(1) Any rules promulgated by the bureau of TennCare under this subsection (e) shall be developed in consultation with the comptroller of the Treasury and with the Tennessee Health Care Association; and

(2) Any rules or regulations shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5; provided, however, that the bureau of TennCare shall not promulgate emergency rules under this subsection (e) as defined in § 4-5-208.

SECTION 7. This act shall take effect July 1, 2017, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

Signature of Sponsor

AMEND Senate Bill No. 214* House Bill No. 647

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following as a new part:

71-5-1501. This part shall be known and may be cited as the "Annual Coverage Assessment Act of 2017".

71-5-1502.

As used in this part, unless the context otherwise requires:

(1) "Annual coverage assessment" means the annual assessment imposed on covered hospitals as set forth in this part;

(2) "Annual coverage assessment base" is a covered hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2008, on file with CMS as of September 30, 2009, subject to the following qualifications:

(A) If a covered hospital does not have a full twelve-month medicare cost report for 2008 on file with CMS but has a full twelve-month cost report for a subsequent year, the first full twelve-month medicare cost report for a year following 2008 on file with CMS shall be the annual coverage assessment base;

(B) If a covered hospital was first licensed in 2014 or later and did not replace an existing hospital, and if the hospital has a medicare cost report on file with CMS, the hospital's initial cost report on file with CMS shall be the base for the hospital assessment. If the hospital does not

have an initial cost report on file with CMS but does have a complete twelve-month joint annual report filed with the department of health, the net patient revenue from the twelve-month joint annual report shall be the annual coverage assessment base. If the hospital does not have a medicare cost report or a full twelve-month joint annual report filed with the department of health, the annual coverage assessment base is the covered hospital's projected net patient revenue for its first full year of operation as shown in its certificate of need application filed with the health services and development agency;

(C) If a covered hospital was first licensed in 2014 or later and replaced an existing hospital, the annual coverage assessment base shall be the hospital's initial medicare cost report on file with CMS. If the hospital does not have a medicare cost report on file with CMS, such hospital's annual coverage assessment base shall be either the predecessor hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2008, or, if the predecessor hospital does not have a 2008 medicare cost report, the cost report for the first fiscal year following 2008 on file with CMS;

(D) If a covered hospital is not required to file an annual medicare cost report with CMS, then the hospital's annual coverage assessment base shall be its net patient revenue for the fiscal year ending during calendar year 2008 or the first fiscal year that the hospital was in operation after 2008 as shown in the covered hospital's joint annual report filed with the department of health; and

(E) If a covered hospital's fiscal year 2008 medicare cost report is not contained in any of the CMS healthcare cost report information system files and if the hospital does not meet any of the other qualifications listed in subdivisions (2)(A)-(D), then the hospital shall

submit a copy of the hospital's 2008 medicare cost report to the bureau in order to allow for the determination of the hospital's net patient revenue for the state fiscal year 2017-2018 annual coverage assessment;

(3) "Bureau" means the bureau of TennCare;

(4) "CMS" means the federal centers for medicare and medicaid services;

(5) "Controlling person" means a person who, by ownership, contract, or otherwise, has the authority to control the business operations of a covered hospital. Indirect or direct ownership of ten percent (10%) or more of a covered hospital shall constitute control;

(6) "Covered hospital" means a hospital licensed under title 33 or title 68, as of July 1, 2017, except an excluded hospital;

(7) "Excluded hospital" means:

(A) A hospital that has been designated by CMS as a critical access hospital;

(B) A mental health hospital owned by this state;

(C) A hospital providing primarily rehabilitative or long-term acute care services;

(D) A children's research hospital that does not charge patients for services beyond that reimbursed by third-party payers; and

(E) A hospital that is determined by the bureau as eligible to certify public expenditures for the purpose of securing federal medical assistance percentage payments;

(8) "Medicare cost report" means CMS-2552-96, the cost report for electronic filing of hospitals, for the period applicable as set forth in this section; and

(9) "Net patient revenue" means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on

Worksheet G-3, Column 1, Line 3, of the 2008 medicare cost report excluding long-term care inpatient ancillary revenues, or, in the case of a hospital that did not file a 2008 medicare cost report, comparable data from the first complete cost report filed after 2008 by such hospital.

71-5-1503.

(a) There is imposed on each covered hospital licensed as of July 1, 2017, an annual coverage assessment for fiscal year (FY) 2017-2018 as set forth in this part.

(b) The annual coverage assessment imposed by this part shall not be effective and validly imposed until the bureau has provided the Tennessee Hospital Association with written notice that includes:

(1) A determination from CMS that the annual coverage assessment is a permissible source of revenue that shall not adversely affect the amount of federal financial participation in the TennCare program;

(2) Either:

(A) Approval from CMS for the distribution of the full amount of directed payments to hospitals to offset unreimbursed TennCare costs as defined in § 71-5-1505(d)(2), provided that no assessment installment shall be collected prior to the distribution of the installment of such directed payments;

(B) Approval from CMS for the distribution of the full amount of funds for uncompensated hospital costs set forth in the extension of the section 1115 demonstration project effective December 16, 2016, provided that the bureau shall prioritize the distribution of funds in the same manner as set forth in § 71-5-1504(i)(2)(A)(ii); or

(C) The rules proposed by the bureau pursuant to § 71-5-1504(i)(2); and

(3) Confirmation that all contracts between hospitals and managed care organizations comply with the hospital rate variation corridors set forth in § 71-5-161.

(c) The general assembly intends that the proceeds of the annual coverage assessment not be used as a justification to reduce or eliminate state funding to the TennCare program. The annual coverage assessment shall not be effective and validly imposed if the coverage or the amount of revenue available for expenditure by the TennCare program in FY 2017-2018 is less than:

(1) The governor's FY 2017-2018 recommended budget level; plus

(2) Additional appropriations made by the general assembly to the TennCare program for FY 2017-2018, except to the extent new federal funding is available to replace funds that are appropriated as described in subdivision (c)(1) and that are above the amount that the state receives from CMS under the regular federal matching assistance percentage.

(d)

(1)

(A) The general assembly intends that the proceeds of the annual coverage assessment not be used as justification for any TennCare managed care organization to implement across-the-board rate reductions to negotiated rates with covered or excluded hospitals or physicians in existence on July 1, 2017. For those rates in effect on July 1, 2017, the bureau shall include provisions in the managed care organizations' contractor risk agreements that prohibit the managed care organizations from implementing across-the-board rate reductions to covered or excluded network hospitals or physicians either by category or by type of provider. The requirements of the preceding sentence shall also apply to services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician, but shall not apply

to reductions in benefits or reimbursement for such ancillary services if the reductions:

(i) Are different from those items being restored in § 71-5-1505(d); and

(ii) Have been communicated in advance of implementation to the general assembly and the Tennessee Hospital Association.

(B)

(i) For purposes of this subsection (d), services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician shall include all services where the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than a fifty percent (50%) controlling interest in such ancillary services or settings of care, but shall not include any other ancillary services or settings of care. For across-the-board rate reductions to ancillary services or settings of care, the bureau shall include appropriate requirements for notice to providers in the managed care organizations' contractor risk agreements.

(ii) For purposes of this subsection (d), services or settings of care that are "ancillary" shall mean, but not be limited to, ambulatory surgical facilities, free standing emergency departments, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation, or skilled nursing services.

(iii) For purposes of this subsection (d), "physician" includes a physician licensed under title 63, chapter 6 or chapter 9, and a group practice of physicians that hold a contract with a managed care organization.

(2) This subsection (d) does not preclude good faith negotiations between managed care organizations and covered or excluded hospitals, hospital systems, and physicians on an individualized, case-by-case basis, nor is this subsection (d) intended by the general assembly to serve as justification for managed care organizations in this state, covered or excluded hospitals, hospital systems, or physicians to unreasonably deny any party the ability to enter into such individualized, case-by-case good faith negotiations. Such good faith negotiation necessarily implies mutual cooperation between the negotiating parties and may include, but is not limited to, the right to terminate contractual agreements, the ability to modify negotiated rates, pricing, or units of service, the ability to alter payment methodologies, and the ability to enforce existing managed care techniques or to implement new managed care techniques.

(3) This subsection (d) shall not preclude the full implementation of the requirements set forth in § 71-5-161.

(4) Notwithstanding this subsection (d), if CMS mandates a TennCare program change or a change is required by state or federal law that impacts rates, and that change is required to be implemented by the managed care organizations in accordance with their contracts, or if the annual coverage assessment becomes invalid, then nothing in this part shall prohibit the managed care organizations from implementing any rate changes as may be mandated by the bureau or by state or federal law.

71-5-1504.

(a) The annual coverage assessment established for this part shall be four and fifty-two hundredths percent (4.52%) of a covered hospital's annual coverage assessment base.

(b) The annual coverage assessment shall be paid in installments pursuant to this subsection (b) if the requirements of § 71-5-1503(b) have been satisfied. The bureau shall establish a schedule of four (4) equal installment payments spread evenly throughout FY 2017-2018 with the first installment payment due either fifteen (15) days after the directed payments approved by CMS to offset unreimbursed TennCare costs have been made to hospitals, or if CMS does not approve directed payments to hospitals to offset unreimbursed TennCare costs, then fifteen (15) days after the first payment to hospitals under § 71-11-1505(d)(3).

(c) To facilitate collection of the annual coverage assessment, the bureau shall send each covered hospital, at least thirty (30) days in advance of each installment payment due date, a notice of payment along with a return form developed by the bureau. Failure of a covered hospital to receive a notice and return form, however, shall not relieve a covered hospital from the obligation of timely payment. The bureau shall also post the return form on its website.

(d) Failure of a covered hospital to pay an installment of the annual coverage assessment, when due, shall result in an imposition of a penalty of five hundred dollars ($500) per day until such installment is paid in full. The bureau at its discretion may waive the penalty in the event the hospital establishes that it mailed or electronically transferred payment to the state on or before the date the payment was due.

(e) If a covered hospital ceases to operate after July 1, 2017, and before July 1, 2018, the hospital's total annual coverage assessment shall be equal to its annual coverage assessment base multiplied by a fraction, the denominator of which is the number of calendar days from July 1, 2017, until July 1, 2018, and the numerator of which is the number of days from July 1, 2017, until the date the board for licensing healthcare facilities has recorded as the date that the hospital ceased operation.

(f) If a covered hospital ceases operation prior to payment of its full annual coverage assessment, then the person or persons controlling the hospital as of the date the hospital ceased operation shall be jointly and severally responsible for any remaining annual coverage assessment installments and unpaid penalties associated with previous late payments.

(g) If a covered hospital fails to pay an installment of the annual coverage assessment within thirty (30) days of its due date, the bureau shall suspend the payments to the hospital as required by § 71-5-1505(d)(2) or (3) until the installment is paid and report such failure to the department that licenses the covered hospital. Notwithstanding any other law, failure of a covered hospital to pay an installment of the annual coverage assessment or any refund required by this part shall be considered a license deficiency and grounds for disciplinary action as set forth in the statutes and rules under which the covered hospital is licensed.

(h) In addition to the action required by subsection (g), the bureau is authorized to file a civil action against a covered hospital and its controlling person or persons to collect delinquent annual coverage assessment installments, late penalties, and refund obligations established by this part. Exclusive jurisdiction and venue for a civil action authorized by this subsection (h) shall be in the chancery court for Davidson County.

(i)

(1) If any federal agency with jurisdiction over this annual coverage assessment determines that the annual coverage assessment is not a valid source of revenue or if there is a reduction of the coverage and funding of the TennCare program contrary to § 71-5-1503(c), or if the requirements of §§ 71-5-161 and 71-5-1503(b) are not fully satisfied, or if one (1) or more managed care organizations impose rate reductions contrary to § 71-5-1503(d), then:

(A) No subsequent installments of the annual coverage assessment shall be due and payable; and

(B) No further payments shall be paid to hospitals pursuant to § 71-5-1505(d)(2) or (3) after the date of such event.

(2)

(A) Notwithstanding this part, if CMS discontinues approval of or otherwise fails to approve the full amount of directed payments or unreimbursed hospital cost pool payments to hospitals to offset losses incurred from providing services to TennCare enrollees as authorized under § 71-5-1505(d), then the bureau shall suspend any payments from or to covered hospitals otherwise required by this part and shall promulgate rules that:

(i) Establish the methodology for determining the amounts, categories, and times of payments to hospitals, if any, instead of the payments that otherwise would have been paid under § 71-5-1505(d)(3) if approved by CMS;

(ii) Prioritize payments to hospitals as set forth in § 71-5-1505(d)(3);

(iii) Identify the benefits and services for which funds will be available in order to mitigate reductions or eliminations that otherwise would be imposed in the absence of the coverage assessment;

(iv) Determine the amount and timing of payments for benefits and services identified under subdivisions (i)(2)(A)(ii) and (iii) as appropriate;

(v) Reinstitute payments from or to covered hospitals as appropriate; and

(vi) Otherwise achieve the goals of this subdivision (i)(2).

(B) The rules adopted under this subdivision (i)(2) shall, to the extent possible, achieve the goals of:

(i) Maximizing the amount of federal matching funds available for the TennCare program; and

(ii) Minimizing the variation between payments hospitals will receive under the rules as compared to payments hospitals would have received if CMS had approved the total payments described in § 71-5-1505(d).

(C) Notwithstanding any other law, the bureau is authorized to exercise emergency rulemaking authority to the extent necessary to meet the objectives of this subdivision (i)(2).

(3) Upon occurrence of any of the events set forth in subdivision (i)(1) or (i)(2), the bureau shall then have authority to make necessary changes to the TennCare budget to account for the loss of annual coverage assessment revenue.

(j) A covered hospital or an association representing covered hospitals, the membership of which includes thirty (30) or more covered hospitals, shall have the right to file a petition for declaratory order pursuant to § 4-5-223 to determine if there has been a failure to meet any of the requirements of this part. A covered hospital may not increase charges or add a surcharge based on, or as a result of, the annual coverage assessment.

(k) Notwithstanding this part, if the bureau receives notification from CMS of the determination and approval set forth in § 71-5-1503(b), and if the determination and approval have retroactive effective dates, then:

(1) Annual coverage assessment payments that become due by application of the retroactive determination date from CMS shall be paid to the bureau within thirty (30) days from the date of the bureau notifying the Tennessee Hospital Association that CMS has issued the determination, subject to the provisions of this act requiring that certain payments to hospitals be made prior to payment of assessments; and

(2) Payments to covered hospitals required by § 71-5-1505(d) that become due by application of the retroactive approval date from CMS shall be paid within fifteen (15) days of the bureau notifying the Tennessee Hospital Association that CMS has issued such approval.

71-5-1505.

(a) The funds generated as a result of this part shall be deposited in the maintenance of coverage trust fund created by § 71-5-160, the existence of which is continued as provided in subsection (b). The fund shall not be used to replace any monies otherwise appropriated to the TennCare program by the general assembly or to replace any monies appropriated outside of the TennCare program.

(b) The maintenance of coverage trust fund shall continue without interruption and shall be operated in accordance with § 71-5-160 and this section.

(c) The maintenance of coverage trust fund shall consist of:

(1) The balance of the trust fund remaining as of June 30, 2017;

(2) All annual coverage assessments received by the bureau;

(3) Investment earnings credited to the assets of the maintenance of coverage trust fund; and

(4) Penalties paid by covered hospitals for late payment of assessment installments as described in § 71-5-1504(d).

(d) Monies credited or deposited to the maintenance of coverage trust fund, together with all federal matching funds, shall be available to and used by the bureau only for expenditures in the TennCare program and shall include the following purposes:

(1) Expenditure for benefits and services under the TennCare program that would have been subject to reduction or elimination from TennCare funding for FY 2017-2018, except for the availability of one-time funding for that year only, as follows:

(A) Replacement of across-the-board reductions in covered and excluded hospital and professional reimbursement rates described in the governor's recommended budgets since FY 2011;

(B) Maintenance of essential access hospital payments to the maximum allowed by CMS under the TennCare waiver of at least one hundred million dollars ($100,000,000);

(C) Maintenance of disproportionate share hospital payments to the maximum allowed by CMS under the TennCare waiver of at least eighty-one million six hundred thousand dollars ($81,600,000);

(D) Maintenance of payments to critical access hospitals to achieve reimbursement of full cost of benefits provided to TennCare enrollees up to ten million dollars ($10,000,000);

(E) Maintenance of payments for graduate medical education of at least fifty million dollars ($50,000,000);

(F) Maintenance of reimbursement for medicare part A crossover claims at the lesser of one hundred percent (100%) of medicare allowable or the billed amount;

(G) Avoidance of any coverage limitations relative to the number of hospital inpatient days per year annual cost of inpatient services for a TennCare enrollee;

(H) Avoidance of any coverage limitations relative to the number of nonemergency outpatient visits per year for a TennCare enrollee;

(I) Avoidance of any coverage limitations relative to the number of physician office visits per year for a TennCare enrollee;

(J) Avoidance of coverage limitations relative to the number of laboratory and diagnostic imaging encounters per year for a TennCare enrollee;

(K) Maintenance of coverage for occupational therapy, physical therapy, and speech therapy services;

(L) In the total amount of five hundred seventy-seven thousand four hundred dollars ($577,400) to maintain reimbursement at the emergency care rate for nonemergent care to children aged twelve (12) to twenty-four (24) months to avoid the reduction described in the governor's FY 2017-2018 recommended budget; and

(M) In the total amount of two million sixty-three thousand seven hundred dollars ($2,063,700) to the bureau to offset the elimination of the provision in the TennCare managed care contractor risk agreements for hospitals as follows:

CRA 2.12.9.60-Specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing;

(2) Directed payments to hospitals to offset unreimbursed costs incurred by covered hospitals in providing services to TennCare patients, as approved by CMS. Unreimbursed TennCare costs are defined as the excess of TennCare cost over TennCare net revenue as reported on Schedule E, items (A)(1)(c) and (A)(1)(d) from the hospital's 2015 joint annual report filed with the department of health. TennCare costs are defined as the product of a facility's cost-to-charge ratio times TennCare charges. The amount of the directed payment to covered hospitals shall be no less than thirty-seven and nine tenths percent (37.9%) of unreimbursed TennCare cost for all hospitals licensed by the state that reported unreimbursed TennCare cost on the 2015 joint annual report (JAR), excluding state-owned hospitals. If directed payments to hospitals authorized by CMS do not fully cover the amount of the hospital unreimbursed TennCare costs required to be reimbursed by this section (d)(2), then the remaining balance in the trust

fund shall be used to offset the remaining unreimbursed TennCare costs required to be reimbursed by this section;

(3)

(A) In the event CMS does not approve directed payments to hospitals to offset unreimbursed costs incurred in serving TennCare patients, but instead approves the Unreimbursed Hospital Cost (UHC) pool in the TennCare waiver for such purpose, then payments shall be made from the allocated pool to covered hospitals to offset losses incurred in providing services to TennCare enrollees as set forth in this subdivision (d)(3) as first priority before any other supplemental payments authorized in the TennCare waiver are distributed;

(B) Each covered hospital shall be entitled to payments for FY 2017-2018 of a portion of its unreimbursed cost of providing services to TennCare enrollees. Unreimbursed TennCare costs are defined as the excess of TennCare cost over TennCare net revenue as reported on Schedule E, items (A)(1)(c) and (A)(1)(d) from the hospital's 2015 joint annual report filed with the department of health. TennCare costs are defined as the product of a facility's cost-to-charge ratio times TennCare charges. The amount of the payment to covered hospitals shall be no less than thirty-seven and nine tenths percent (37.9%) of unreimbursed TennCare costs for all hospitals licensed by the state that reported unreimbursed TennCare costs on the 2015 joint annual report (JAR), excluding state-owned hospitals;

(C) If funds are remaining for supplemental pools in the TennCare waiver authority after payments to covered hospitals from the UHC pool for uncompensated costs of serving TennCare patients as required in this subdivision (d)(3), the bureau shall allocate the remaining supplemental payments approved by CMS across the following categories: payments to

essential access hospitals, payments to hospitals based on their status as medicaid disproportionate share hospitals, and payment to the state for certified public expenditures recognized by CMS;

(D) The payments required by this subdivision (d)(3) shall be made in four (4) equal installments. Each installment payment shall be made by the third business day of four (4) successive periods within 2017-2018, with the first period to be the 15th day of the month in which the annual coverage assessment is first levied in accordance with § 71-5-1504. The bureau shall provide to the Tennessee Hospital Association a schedule showing the payments to each hospital at least seven (7) days in advance of the payments; and

(E) The payments required by this subdivision (d)(3) may be made by the bureau directly to the hospitals, or the bureau may transfer the funds to one (1) or more managed care organizations with the direction to make payments to hospitals as required by this subsection (d). The payments to a hospital pursuant to this subdivision (d)(3) shall not be considered part of the reimbursement to which a hospital is entitled under its contract with a TennCare managed care organization;

(4) Refunds to covered hospitals based on the payment of annual coverage assessments or penalties to the bureau through error, mistake, or a determination that the annual coverage assessment was invalidly imposed; and

(5) Payments authorized under rules promulgated by the bureau pursuant to § 71-5-1504(i)(2).

(e) If a hospital closes or changes status from a covered hospital to an excluded hospital and consequently reduces the amount of the annual coverage assessment to the extent that the amount is no longer sufficient to cover the total cost of the items included in subsection (d), the payments for these items may be adjusted by an amount equal to the shortfall, including the federal financial participation. The items to be

adjusted and the amounts of the adjustments shall be determined by the bureau in consultation with hospitals.

(f) The bureau shall modify the contracts with TennCare managed care organizations and otherwise take action necessary to assure the use and application of the assets of the maintenance of coverage trust fund, as described in subsection (d).

(g) The bureau shall submit requests to CMS to modify the medicaid state plan, the contractor risk agreements, or the TennCare II Section 1115 demonstration project, as necessary, to implement the requirements of this part.

(h) At quarterly intervals beginning September 1, 2017, the bureau shall submit a report to the finance, ways and means committees of the senate and the house of representatives, to the health and welfare committee of the senate, and to the health committee of the house of representatives, which report shall include:

(1) The status, if applicable, of the determination and approval by CMS set forth in § 71-5-1503(b) of the annual coverage assessment;

(2) The balance of funds in the maintenance of coverage trust fund; and

(3) The extent to which the maintenance of coverage trust fund has been used to carry out this part.

(i) No part of the maintenance of coverage trust fund shall be diverted to the general fund or used for any purpose other than as set forth in this part.

71-5-1506.

This part shall expire on June 30, 2018; provided, however, that the following rights and obligations shall survive such expiration:

(1) The authority of the bureau to impose late payment penalties and to collect unpaid annual coverage assessments and required refunds;

(2) The rights of a covered hospital or an association of covered hospitals to file a petition for declaratory order to determine compliance with this part;

(3) The existence of the maintenance of coverage trust fund and the obligation of the bureau to use and apply the assets of the maintenance of coverage trust fund; and

(4) The obligation of the bureau to implement and maintain the requirements of § 71-5-161.

SECTION 2. This act shall take effect July 1, 2017, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 188* House Bill No. 649

by deleting all language following the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 71-5-2507(b), is amended by deleting the period (.) at the end of the first sentence of the subsection and substituting instead the following:

; and is authorized to make arrests for offenses involving criminal fraud and abuse of the TennCare program and any other violations of state criminal law related to the operation of TennCare.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED	
Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 806 **House Bill No. 770***

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 68, Chapter 1, Part 1, is amended by adding the following as a new, appropriately designated section:

(a) If approved by the department of health, any nongovernmental organization, including an organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors, may establish and operate a needle and hypodermic syringe exchange program. The objectives of the program shall be to do all of the following:

(1) Reduce the spread of human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), viral hepatitis, and other bloodborne diseases in this state;

(2) Reduce needle stick injuries to law enforcement officers and other emergency personnel; and

(3) Encourage individuals who inject drugs to enroll in evidence-based treatment.

(b) Programs established pursuant to this section shall offer all of the following:

(1) Disposal of used needles and hypodermic syringes;

(2) Needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. No public funds may be used to purchase needles, hypodermic syringes, or other injection supplies;

(3) Reasonable and adequate security of program sites, equipment, and personnel. Written plans for security shall be provided to the law enforcement offices with jurisdiction in the program location and shall be updated annually;

(4) Educational materials on all of the following:

(A) Overdose prevention;

(B) The prevention of HIV, AIDS, and viral hepatitis transmission;

(C) Drug abuse prevention;

(D) Treatment for mental illness, including treatment referrals; and

(E) Treatment for substance abuse, including referrals for medication assisted treatment;

(5) Access to naloxone for the treatment of a drug overdose, or referrals to programs that provide access to naloxone for the treatment of a drug overdose; and

(6) Personal consultations from a program employee or volunteer concerning mental health or addiction treatment as appropriate for each individual requesting services.

(c)

(1) It is an exception to the application of title 39, chapter 17, part 4, if an employee, volunteer, or participant of a program established pursuant to this section possesses any of the following:

(A) Needles, hypodermic syringes, or other injection supplies obtained from or returned to a program established pursuant to this section; or

(B) Residual amounts of a controlled substance contained in a used needle, used hypodermic syringe, or used injection supplies

obtained from or returned to a program established pursuant to this section.

(2)

(A) The exception provided in this subsection (c) shall apply only if the person claiming the exception provides written verification that a needle, syringe, or other injection supplies were obtained from a needle and hypodermic syringe exchange program established pursuant to this section.

(B) In addition to any other applicable immunity or limitation on civil liability, a law enforcement officer who, acting on good faith, arrests or charges a person who is thereafter determined to be entitled to immunity from prosecution under this section shall not be subject to civil liability for the arrest or filing of charges.

(d) Prior to commencing operations of a program established pursuant to this section and obtaining approval from the department of health as required by subsection (a), the nongovernmental organization shall report to the department of health all of the following information:

(1) The legal name of the organization or agency operating the program;

(2) The areas and populations to be served by the program; and

(3) The methods by which the program will meet the requirements of subsection (b).

(e) Not later than one (1) year after commencing operations of a program established pursuant to this section, and every twelve (12) months thereafter, each organization operating such a program shall report the following information to the department of health:

(1) The number of individuals served by the program;

(2) The number of needles, hypodermic syringes, and needle injection supplies dispensed by the program and returned to the program;

(3) The number of naloxone kits distributed by the program; and

(4) The number and type of treatment referrals provided to individuals served by the program, including a separate report of the number of individuals referred to programs that provide access to naloxone that is approved by the federal food and drug administration for the treatment of a drug overdose.

(f) The commissioner of health is authorized to promulgate rules to effectuate the purposes of this act. The rules shall be promulgated in accordance with the Uniform Administrative Procedures Act compiled in title 4, chapter 5.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

_____

Signature of Sponsor

AMEND Senate Bill No. 1230 House Bill No. 810*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. This act shall be known and may be cited as the "Elderly and Vulnerable Adult Protection Act."

SECTION 2. Tennessee Code Annotated, Title 39, Chapter 15, is amended by adding the following as a new, appropriately designated part:

39-15-501.

As used in this part, unless the context otherwise requires:

(1) "Abuse" means the infliction of physical harm or psychological injury on an elderly or vulnerable adult;

(2) "Caretaker":

(A) Means a person, as defined in § 39-11-106(a), who has a duty to provide care, or who has otherwise affirmatively assumed a duty for an elderly or vulnerable adult, arising by contract, by formal or informal agreement, or by means of a court order from a court of competent jurisdiction; and

(B) Does not include a financial institution as a caretaker of funds or other assets unless the financial institution has entered into an agreement, or has been appointed by a court of competent jurisdiction, to act as a trustee with regard to the property of the adult;

(3) "Elderly adult" means a person sixty-five (65) years of age or older;

(4) "Financial exploitation" means the unlawful appropriation or use of an elderly or vulnerable adult's property, as defined in § 39-11-106(a), for one's own benefit or that

of a third party. For purposes of this subdivision (4), the state may establish that an unlawful appropriation or use has occurred through theft, undue influence, coercion, harassment, duress, deception, fraud, intimidation, false representation, or false pretenses. If the unlawful appropriation or use has occurred through the use of an instrument that conferred a fiduciary duty on another person or a third party, the state is not required to prove that an appropriation or use of property was unlawful, so long as the state establishes an intent to deceive or defraud by the fiduciary in obtaining the right to act in a fiduciary capacity for the elderly or vulnerable adult;

(5)

(A) "Neglect" means:

(i) The failure of a caretaker to provide the care, supervision, or services necessary to maintain the physical and mental health of an elderly or vulnerable adult, including, but not limited to, the provision of food, water, clothing, medicine, shelter, medical services, and any medical treatment plan prescribed by a healthcare professional, hygiene, or supervision that a reasonable person would consider essential for the well-being of an elderly or vulnerable adult;

(ii) The failure of a caretaker to make a reasonable effort to protect an elderly or vulnerable adult from abuse, neglect, or exploitation by others;

(iii) Abandonment, which is the knowing desertion or forsaking of an elderly or vulnerable adult by a caretaker under circumstances in which there is a reasonable likelihood that bodily injury or psychological injury could occur; or

(iv) Confinement, which is the knowing restriction of movement of an elderly or vulnerable adult by a caretaker. Restricting one's movement includes, but is not limited to, the use of force, medication, intimidation, or

restraint. Confinement does not include restricting an elderly or vulnerable adult's movement for the safety of the elderly or vulnerable adult under current medical supervision; and

(B) Neglect can be the result of repeated conduct or a single incident;

(6) "Physical harm" means any physical pain or injury, regardless of gravity or duration;

(7) "Psychological injury" means an injury to the intellectual functioning or emotional state of an elderly or vulnerable adult as evidenced by an observable or measurable reduction in the elderly or vulnerable adult's ability to function within that adult's customary range of performance or behavior;

(8) "Relative" means a spouse; child, including stepchild, adopted child, or foster child; parent, including stepparent, adoptive parent, or foster parent; sibling of the whole or half-blood; step-sibling; grandparent, of any degree; grandchildren, of any degree; and aunt, uncle, niece, and nephew, of any degree, who:

(A) Resides with or has frequent or prolonged contact with the elderly or vulnerable adult; and

(B) Knows or reasonably should know that the elderly or vulnerable adult is unable to adequately provide for the adult's own care or financial resources;

(9) "Serious physical harm" means physical harm of such gravity that:

(A) Would normally require medical treatment, medication, or hospitalization;

(B) Involves acute pain of such duration that it results in substantial suffering;

(C) Involves any degree of prolonged pain or suffering; or

(D) Involves any degree of prolonged incapacity;

(10) "Serious psychological injury" means a psychological injury of such gravity as would normally require psychological treatment, medication, or hospitalization;

(11) "Sexual exploitation" means an act of a sexual nature committed upon or in the presence of an elderly or vulnerable adult without that adult's consent. Sexual exploitation includes, but is not limited to, fondling, exposure of genitals to an elderly or vulnerable adult, exposure of sexual acts to an elderly or vulnerable adult, or exposure of an elderly or vulnerable adult's sexual organs. Sexual exploitation does not include any act intended for a valid medical purpose, or any act that may reasonably be construed to be a normal caregiving act or an appropriate display of affection; and

(12) "Vulnerable adult" means a person eighteen (18) years of age or older who, because of intellectual disability or physical dysfunction, is unable to fully manage the person's own resources, carry out all or a portion of the activities of daily living, or fully protect against neglect, exploitation, or hazardous or abusive situations without assistance from others.

39-15-502.

(a) It is an offense for a person to knowingly abuse an elderly or vulnerable adult.

(b) The offense of abuse of an elderly adult is a Class E felony.

(c) The offense of abuse of a vulnerable adult is a Class D felony.

39-15-503.

(a) A person commits the offense of aggravated abuse of an elderly or vulnerable adult who knowingly commits abuse pursuant to § 39-15-502, and:

(1) The act results in serious psychological injury or serious physical harm;

(2) A deadly weapon is used to accomplish the act;

(3) The abuse is committed by two (2) or more persons; or

(4) The abuse results in serious bodily injury, as defined in § 39-11-106.

(b) In order to prosecute and convict a person for a violation of subdivision (a)(1), it is not necessary for the state to prove the elderly or vulnerable adult sustained

serious bodily injury as required by § 39-13-102, but only that the elements set out in subdivision (a)(1) occurred.

(c) A violation of subdivision (a)(1) is a Class C felony.

(d) A violation of subdivision (a)(2), (a)(3), or (a)(4) is a Class B felony.

39-15-504.

(a) It is an offense for a caretaker to knowingly neglect an elderly adult or vulnerable adult, so as to adversely affect the person's health or welfare.

(b) The offense of neglect of an elderly adult is a Class E felony.

(c) The offense of neglect of a vulnerable adult is a Class D felony.

(d) If the neglect is a result of abandonment or confinement and no injury occurred, then the neglect by abandonment or confinement of an elderly or vulnerable adult is a Class A misdemeanor.

39-15-505.

(a) A caretaker commits the offense of aggravated neglect of an elderly or vulnerable adult who commits neglect pursuant to § 39-15-504, and the act:

(1) Results in serious psychological injury or serious physical harm; or

(2) Results in serious bodily injury as defined by § 39-11-106.

(b) In order to prosecute and convict a person for a violation of subdivision (a)(1), it is not necessary for the state to prove the adult sustained serious bodily injury as required by § 39-13-102, but only that the elements set out in subdivision (a)(1) occurred.

(c) A violation of subdivision (a)(1) is a Class C felony.

(d) A violation of subdivision (a)(2) is a Class B felony.

39-15-506.

(a) It is an offense for any person to knowingly sexually exploit an elderly adult or vulnerable adult.

(b) The offense of sexual exploitation of an elderly adult is a Class E felony.

(c) The offense of sexual exploitation of a vulnerable adult is a Class D felony.

39-15-507.

(a) It is an offense for any person to knowingly financially exploit an elderly or vulnerable adult.

(b) A violation of this section shall be punished as theft pursuant to § 39-14-105; provided, however, that the violation shall be punished one (1) classification higher than is otherwise provided in § 39-14-105. In no event shall a violation of this section be less than a Class D felony.

(c)

(1) If a person is charged with financial exploitation that involves the taking or loss of property valued at more than five thousand dollars ($5,000), a prosecuting attorney may file a petition with the circuit, general sessions, or chancery court of the county in which the defendant has been charged to freeze the funds, assets, or property of the defendant in an amount up to one hundred fifty percent (150%) of the alleged value of funds, assets, or property in the defendant's pending criminal proceeding for purposes of restitution to the victim. The hearing on the petition may be held ex parte if necessary to prevent additional exploitation of the victim.

(2) Upon a showing of probable cause in the ex parte hearing, the court shall issue an order to freeze or seize the assets of the defendant in the amount calculated pursuant to subdivision (c)(1). A copy of the freeze or seize order shall be served upon the defendant whose assets have been frozen or seized.

(3) The court's order shall prohibit the sale, gifting, transfer, or wasting of the assets of the elderly or vulnerable adult, both real and personal, owned by, or vested in, such person, without the express permission of the court.

(4) At any time within thirty (30) days after service of the order to freeze or seize assets, the defendant or any person claiming an interest in the assets

may file a motion to release the assets. The court shall hold a hearing on the motion no later than ten (10) days from the date the motion is filed.

(d) In any proceeding to release assets, the state has burden of proof, by a preponderance of the evidence, to show that the defendant used, was using, is about to use, or is intending to use any assets in any way that constitutes or would constitute an offense under subsection (a). If the court finds that any assets were being used, are about to be used, or are intended to be used in any way that constitutes or would constitute an offense under subsection (a), the court shall order the assets frozen or held until further order of the court.

(e) If the prosecution of the charge under subsection (a) is dismissed or a nolle prosequi is entered, or if a judgment of acquittal is entered, the court shall vacate the order to freeze or seize the assets.

(f) In addition to other remedies provided by law, an elderly or vulnerable adult in that person's own right, or by conservator or next friend, has a right of recovery in a civil action for financial exploitation or for theft of the person's money or property whether by fraud, deceit, coercion, or otherwise. The right of action against a wrongdoer shall not abate or be extinguished by the death of the elderly or vulnerable adult, but passes as provided in § 20-5-106, unless the alleged wrongdoer is a relative, in which case the cause of action passes to the victim's personal representative.

39-15-508.

(a) Any transfer of property as defined in § 39-11-106(a) valued in excess of one thousand dollars ($1,000) in a twelve-month period, whether in a single transaction or multiple transactions, by an elderly or vulnerable adult to a non-relative whom the transferor has known for fewer than two (2) years before the first transfer and for which the transferor did not receive reciprocal value in goods or services creates a permissive inference that the transfer was effectuated without the effective consent of the owner.

(b) Subsection (a) applies regardless of whether the transfer or transfers are denoted by the parties as a gift or loan except that it shall not apply to a valid loan evidenced in writing and which includes definite repayment dates. In the event repayment of any such loan is in default, in whole or in part, for more than sixty (60) days, the inference described in subsection (a) applies. Subsection (a) does not apply to persons or entities that operate a legitimate financial institution.

(c) This section does not apply to valid charitable donations to nonprofit organizations qualifying for tax exempt status under the internal revenue code.

(d) A court shall instruct jurors that they may, but are not required to, infer that the transfer of money or property was effectuated without the effective consent of the owner, with the intent to deprive the owner of the money or property, upon proof beyond a reasonable doubt of the facts listed in subsection (a). The court shall also instruct jurors that they may find a defendant guilty only if persuaded that each element of the offense has been proved beyond a reasonable doubt.

39-15-509. [Reserved.]

39-15-510.

(a) In cases where an alleged offense has been committed against an elderly or vulnerable adult, upon the state's motion, the court shall conduct a hearing to preserve the testimony of the victim within sixty (60) days of the defendant's initial court appearance whether the case originates in general sessions court or criminal court.

(b) An elderly or vulnerable adult victim's inability to attend judicial proceedings due to illness, or other mental or physical disability, shall be considered exceptional circumstances upon the state's motion to preserve testimony pursuant to Rule 17 of the Tennessee Rules of Criminal Procedure.

(c) The court shall consider an affidavit executed by the elderly or vulnerable adult's treating physician stating that the elderly or vulnerable adult is unable to attend

court due to illness or other mental or physical disability as prima facie evidence of the need to preserve witness testimony by the taking of the adult's out-of-court deposition.

(d) The court shall order the defendant's attendance to the out-of-court deposition. The defendant may waive the defendant's attendance in writing.

39-15-511.

(a) The secretary of state shall create a no-solicitation list, which shall be exempt from § 10-7-503, specifically for elderly or vulnerable adults. The elderly or vulnerable adult, or the adult's designee, may register the adult's address, phone number, or both, to be placed on the list.

(b) Solicitors shall not solicit via home visit, mailing, telephone, electronic communication, or any other means, any individual registered on the list.

(c) The secretary of state may promulgate rules, as necessary, to carry out this section.

(d) A violation of subsection (b) is a Class B misdemeanor.

39-15-512.

(a) Any person having reasonable cause to suspect that an elderly or vulnerable adult is suffering or has suffered abuse, neglect, financial exploitation, or sexual exploitation shall report such abuse, neglect, or exploitation to adult protective services pursuant to title 71, chapter 6.

(b) Any person who knowingly fails to report as required in subsection (a) commits a Class A misdemeanor.

(c) Upon good cause shown, adult protective services shall cooperate with law enforcement to identify those persons, as defined in § 39-11-106(a), who knowingly fail to report abuse, neglect, financial exploitation, or sexual exploitation of an elderly or vulnerable adult.

39-15-513.

(a) If a person convicted of abuse, neglect, or exploitation under this part has no parental rights to the victim of such offense at the time of a court order issued pursuant to this section, then the court may, in its discretion, and in addition to any other punishment otherwise authorized by law, order the person to refrain from having any contact with the victim of the offense, including, but not limited to, attempted contact by telephone, in writing, by electronic mail, by internet services, including social networking websites, or by any other form of electronic communication.

(b)

(1) Following a conviction for a violation of § 39-15-502, § 39-15-503, § 39-15-504, § 39-15-505, § 39-15-506, or § 39-15-507, and at the discretion of the court, the clerk of the court shall notify the department of health of the conviction by sending a copy of the judgment in the manner set forth in § 68-11-1003 for inclusion on the registry pursuant to title 68, chapter 11, part 10.

(2) Upon receipt of a judgment of conviction for a violation of an offense set out in subdivision (b)(1), the department shall place the person or persons convicted on the registry of persons who have abused, neglected, or financially or sexually exploited an elderly or vulnerable adult as provided in § 68-11-1003(c).

(3) Upon entry of the information in the registry, the department shall notify the person convicted, at the person's last known mailing address, of the person's inclusion on the registry. The person convicted shall not be entitled or given the opportunity to contest or dispute either the prior hearing conclusions or the content or terms of any criminal disposition, or attempt to refute the factual findings upon which the conclusions and determinations are based. The person convicted may challenge the accuracy of the report that the criminal disposition has occurred, such hearing conclusions were made, or any factual issue related to the correct identity of the person. If the person convicted makes such a

challenge within sixty (60) days of notification of inclusion on the registry, the commissioner, or the commissioner's designee, shall afford the person an opportunity for a hearing on the matter that complies with the requirements of due process and the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(c)

(1) In addition to any other punishment that may be imposed for a violation of § 39-15-502, § 39-15-503, § 39-15-504, § 39-15-505, § 39-15-506, or § 39-15-507, the court shall impose a fine of not less than five hundred dollars ($500) for Class A or Class B misdemeanor convictions, and a fine of not less than one thousand dollars ($1,000) for felony convictions. The fine shall not exceed the maximum fine established for the appropriate offense classification.

(2) The person convicted shall pay the fine to the clerk of the court imposing the sentence, who shall transfer it to the district attorney of the judicial district in which the case was prosecuted. The district attorney shall credit the fine to a fund established for the purpose of educating, enforcing, and providing victim services for elderly and vulnerable adult prosecutions.

SECTION 3. Tennessee Code Annotated, Sections 39-14-111, 71-6-117, and 71-6-119, are deleted in their entireties.

SECTION 4. Tennessee Code Annotated, Section 39-13-202(a)(2), is amended by deleting the language "kidnapping" and substituting instead the language "kidnapping, aggravated abuse of an elderly or vulnerable adult, aggravated neglect of an elderly or vulnerable adult".

SECTION 5. Tennessee Code Annotated, Section 39-13-502(a), is amended by adding the following language as new subdivisions:

(4) The defendant knows or has reason to know that the victim is an elderly adult as defined by § 39-15-501, who is a resident of a healthcare provider, as defined by § 9-

8-311, and the penetration is accomplished by a caretaker or employee who is paid by either the healthcare provider, the victim, or the victim's family; or

(5) The defendant knows or has reason to know the victim is a vulnerable adult, as defined by § 39-15-501.

SECTION 6. Tennessee Code Annotated, Section 39-13-504(a), is amended by renumbering the existing subdivision (a)(4) as subdivision (a)(6) and inserting the following as new subdivisions (a)(4) and (a)(5):

(4) The defendant knows or has reason to know that the victim is an elderly adult, as defined by § 39-15-501, who is a resident of a healthcare provider, as defined by § 9-8-311, and the unlawful sexual contact is accomplished by a caretaker or employee who is paid by either the healthcare provider, the victim, or the victim's family;

(5) The defendant knows or has reason to know the victim is a vulnerable adult, as defined by § 39-15-501; or

SECTION 7. Tennessee Code Annotated, Section 40-11-150(k)(1), is amended by deleting the language "§ 71-6-119" and substituting instead the language "§ 39-15-502, § 39-15-503, § 39-15-504, § 39-15-505, or § 39-15-506" and is further amended by deleting the language "§ 71-6-102" and substituting instead the language "§ 39-15-501".

SECTION 8. Tennessee Code Annotated, Section 40-35-313(a)(1)(B)(i)(c), is amended by deleting the language "a violation of § 71-6-117 or § 71-6-119" and substituting instead the language "a violation of § 39-15-504, § 39-15-505, or § 39-15-506".

SECTION 9. Tennessee Code Annotated, Section 40-35-313(a)(3)(A), is amended by deleting the language "on or after July 1, 2004" and substituting instead the language "on or after July 1, 2004, and prior to July 1, 2017, or charged with a violation of § 39-15-502 or § 39-15-504 on or after July 1, 2017".

SECTION 10. Tennessee Code Annotated, Section 71-6-120(h), is amended by deleting the language "71-6-117" and substituting instead the language "39-15-507".

SECTION 11. Tennessee Code Annotated, Section 71-6-124(a)(1)(A), is amended by deleting the language "§ 71-6-117" wherever it appears and substituting instead the language "§ 39-15-502, § 39-15-503, § 39-15-504, § 39-15-505, § 39-15-506, or § 39-15-507".

SECTION 12. For the purposes of promulgating the rules, this act shall take effect upon becoming law, the public welfare requiring it. For all other purposes, this act shall take effect July 1, 2017, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED	
Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 448* **House Bill No. 1090**

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 63-3-209(2)(B), is amended by deleting the subdivision and substituting instead the following:

A resident continuing such resident's clinical education in a residency accredited by the National Commission on Orthotic and Prosthetic Education; provided, that such person has first registered as a resident with the board; or

SECTION 2. Tennessee Code Annotated, Section 63-3-202(a), is amended by adding the following as a new subdivision:

Establish a registration process for residents as prescribed in § 63-3-209(2)(B).

SECTION 3. Tennessee Code Annotated, Title 63, Chapter 3, Part 2, is amended by adding the following as a new section:

A licensed orthotist or prosthetist may utilize one (1) or more non-licensed persons to assist in:

(1) The performance of minor repairs on devices which have been previously dispensed to patients; and

(2) The performance of other tasks approved by the board of podiatric medical examiners.

SECTION 4. This act shall take effect July 1, 2017, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

Signature of Sponsor

AMEND Senate Bill No. 893* **House Bill No. 1149**

by deleting all language after the enacting clause and substituting the following:

SECTION 1. Tennessee Code Annotated, Section 68-3-502, is amended by adding the following as a new subsection (i):

(i)

(1) When a county medical examiner suspects that suicide may be a potential manner of death, the medical examiner is encouraged to consult the decedent's treating mental health professional, if known or applicable, prior to determination of manner of death.

(2)

(A) If, after inquiry by the county medical examiner pursuant to title 38, chapter 7, part 1, the deceased's next of kin disputes the manner of death determination on the death certificate, the next of kin may seek reconsideration of the manner of death determination.

(B) To seek reconsideration, the next of kin must submit a written request for reconsideration to the county medical examiner who signed the death certificate, the deputy state medical examiner of the regional forensic center where the autopsy was performed, and the commissioner of health, stating the nature and reasons for the reconsideration. If the county medical examiner who signed the death certificate is no longer the county medical examiner, then the notice shall be sent to the current county medical examiner instead. The written request for reconsideration must be submitted within one (1) year of the date the death certificate is

filed with the office of vital records and must be supported by a signed affidavit.

(3) Within thirty (30) days after receiving notice of the reconsideration request, the county medical examiner shall meet with the requesting next of kin. The meeting shall be either in person or via teleconference, at the discretion of the requesting next of kin. At the meeting, each party shall present the reasons supporting their position with respect to the manner of death, including any relevant documentation. The county medical examiner shall make a written determination on the reconsideration within thirty (30) days after the reconsideration meeting and shall notify the requesting next of kin, the deputy state medical examiner of the regional forensic center where the autopsy was performed, and the commissioner of health in writing. If the medical examiner who signed the medical certification is no longer in a position as county medical examiner, then the current county medical examiner shall participate in the reconsideration meeting and issue the written determination on the reconsideration instead.

(4) If, after reconsideration, the county medical examiner finds a change in the manner of death determination is warranted, the county medical examiner shall file an affidavit within thirty (30) days directing the office of vital records to issue an amended death certificate to reflect the county medical examiner's findings as to manner of death.

(5)

(A) If, after reconsideration, the determination of manner of death is still disputed by the requesting next of kin, the requesting next of kin may seek further review of the determination by petitioning the deputy state medical examiner for the regional forensic center in which the autopsy was performed, on a form prescribed by the department of health, to review the medical records, hospital records, death certificate,

investigative reports, and any other documentary evidence deemed necessary of the deceased. The deputy state medical examiner for the regional forensic center shall respond to the requesting next of kin detailing the findings within thirty (30) days with a written report. The report shall state whether the deputy state medical examiner agrees with the determination of manner of death on the death certificate, and, if the deputy state medical examiner for the regional forensic center disagrees with the determination of manner of death on the death certificate, the report shall detail those findings and the basis for the disagreement. The report shall be sent to the next of kin and the commissioner of health.

(B) If the deputy state medical examiner finds a change in the manner of death determination is warranted, the deputy state medical examiner shall file an affidavit within thirty (30) days directing the office of vital records to issue an amended death certificate to reflect the deputy state medical examiner's findings as to manner of death.

(6)

(A) If, after review by the deputy state medical examiner for the regional forensic center, the determination of manner of death is unchanged, then the requesting next of kin may seek mediation with the deputy state medical examiner for the regional forensic center with a Rule 31 mediator under the Rules of the Supreme Court of Tennessee, at the sole expense of the requesting next of kin.

(B) If the deputy state medical examiner finds a change in the manner of death determination is warranted following mediation, the deputy state medical examiner shall file an affidavit within thirty (30) days directing the office of vital records to issue an amended death certificate to reflect the deputy state medical examiner's findings as to manner of death.

(7) The department of health shall maintain a notice of decedents' next of kin rights with regard to this subsection (i) on its public website.

(8) As used in this subsection (i), "next of kin" means the person who has the highest priority pursuant to § 62-5-703.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

_____

Signature of Sponsor

AMEND Senate Bill No. 883* **House Bill No. 1320**

by deleting the preamble of the bill in its entirety and substituting instead the following:

WHEREAS, half of all pregnancies in the United States each year are unintended; and

WHEREAS, a broad range of acceptable and effective contraceptives can reduce the chance of unintended pregnancy; and

WHEREAS, a client-centered approach affords women the opportunity to select the contraceptive method that is most appropriate based on her personal preferences and medical needs; and

WHEREAS, Voluntary Reversible Long-Acting Contraception (VRLAC), also known as Long-Acting Reversible Contraceptives (LARCs), are extremely effective at preventing pregnancy, are extremely safe, and can provide protection for up to ten years; and

WHEREAS, according to the Centers for Disease Control and Prevention, only about seven percent of women aged fifteen to forty-four currently use VRLACs or LARCs; and

WHEREAS, in Colorado, where there has been a program to make VRLACs or LARCs more widely accessible, the state reported a forty-eight percent decline in birthrates among teens and a forty-eight percent decline in teen abortions; and

WHEREAS, high upfront costs, a lack of adequate training for healthcare professionals, administrative barriers, and insufficient information and education have made VRLACs or LARCs more difficult to access than other forms of birth control; and

WHEREAS, this law is enacted to protect the health, safety, and welfare of women and families by making VRLACs or LARCs more accessible; now, therefore,

AND FURTHER AMEND by deleting Section 2 and substituting instead the following:

SECTION 2. Tennessee Code Annotated, Title 68, Chapter 1, Part 1, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Family planning centers" means health clinics that receive funding under the Title X program overseen by the U.S. department of health and human services, Pub. L. 91-572, as well as other health clinics that the commissioner of health finds are qualified and willing to perform comprehensive family planning services; and

(2) "Voluntary reversible long-acting contraception" or "VRLACs," also known as "long-acting reversible contraceptives" or "LARCs," means highly effective methods of contraception that last for several years and are easy to use. VRLACs include, but are not limited to, intrauterine contraceptives and birth control implants.

(b)

(1) The department of health shall administer a program to improve access to VRLACs for women.

(2) The program shall include:

(A) Training for family planning centers regarding contraceptive methods, including VRLACs, client-centered and non-coercive counseling strategies, and managing side effects;

(B) Training for all public health facilities to ensure that they are qualified and able to provide forms of contraception, including VRLACs;

(C) Assistance to family planning centers regarding administrative or technical issues such as coding, billing, pharmacy rules, and clinic management related to the provision of forms of contraception, including VRLACs and other methods;

(D) General financial support to expand the capacity of family planning centers to provide VRLACs, to train and staff providers, and to keep supplies in stock and available for same-day access by patients;

(E) Education and outreach to the public about the availability, effectiveness, and safety of contraception including VRLAC;

(F) A study of making as many contraceptive methods as possible available both over-the-counter and directly through pharmacies, as California and Oregon have done; and

(G) Other services the commissioner of health deems necessary to improve access to comprehensive family planning options.